LYME DISEASE CASE REPORT - Page 1 of 2

Indiana State Department of Health
State Form 51933 (10-04)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✓●
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name

First Name **MI** **Phone Number** - -

Number & Street Address

City **State** **ZIP Code** -

County **Date of Birth** / / **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

Sex:
○ Male ○ Female ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Section 2. Clinical Information

Symptoms and Signs of Current Episode (Please mark each question):

DERMATOLOGIC:			
Erythema migrans (physician diagnosed EM at least 5 cm in diameter)?	○ Yes	○ No	○ Unknown
RHEUMATOLOGIC:			
Arthritis characterized by brief attacks of swelling in one or a few joints?	○ Yes	○ No	○ Unknown
NEUROLOGIC:			
Bell's palsy or other cranial neuritis?	○ Yes	○ No	○ Unknown
Radiculoneuropathy?	○ Yes	○ No	○ Unknown
Lymphocytic meningitis?	○ Yes	○ No	○ Unknown
Encephalitis/Encephalomyelitis?	○ Yes	○ No	○ Unknown
Antibody to B. burgdorfen higher in CSF than serum?	○ Yes	○ No	○ Unknown or Not Tested
CARDIOLOGIC:			
2nd or 3rd degree atrioventricular block?	○ Yes	○ No	○ Unknown

Other Clinical

Date of Onset / / **Date of Diagnosis** / / **Date of Report to Health Department** / /

Other History:

Was the patient hospitalized for the current episode? ○ Yes ○ No ○ Unknown

Name of antibiotic(s) used this episode **Use in days**

Was the patient pregnant at the time of illness? ○ Yes ○ No ○ Unknown

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Section 2. Clinical Information (continued)

If EM was diagnosed, did the patient travel out of county of residence during the month prior to EM onset?

○ Yes ○ No ○ Unknown

If Yes, County **State**

Where was the patient most likely exposed?

County **State**

Section 3. Laboratory Results

Lyme Antibody:	○ Positive	○ Negative	○ Equivocal	○ Not done/Unknown
Western Blot IgM:	○ Positive	○ Negative	○ Equivocal	○ Not done/Unknown
Western Blot IgG:	○ Positive	○ Negative	○ Equivocal	○ Not done/Unknown
Other:	○ Positive	○ Negative	○ Equivocal	○ Not done/Unknown

If Other, specify

Physician's Name

Physician's Address

City **State** **ZIP Code** -

- - **Physician's Phone**

Section 4. Comments/Follow-up

Comments:

Person Completing Form (if not physician)

Address

- - **Phone Number** **Date** / /

THIS FORM CONTAINS CONFIDENTIAL INFORMATION PER 410 IAC 1-2.3